

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6923

CERTIFICATE OF DEATH

Reg. Dist. No. 06917

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reisterstown Community Hosp.</u>				d. STREET ADDRESS <u>416 W. Cannon</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Milton</u> Last <u>Barwick</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1907</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Barwick</u>				14. MOTHER'S M maiden name <u>Marietta Meredith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-2172</u>		17. INFORMANT <u>Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>58</u> , to <u>June 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. <u>Chestertown, Md.</u> <u>6-26-58</u> PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 27</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

1. Name of Deceased: John A. Smith

2. Sex: Male

3. Age: 45 Years

4. Date of Death: Jan 15 1901

5. Place of Death: At Home

6. Cause of Death: Heart Disease

7. Signature of Physician: Dr. J. B. Brown

8. Signature of Registrar: Wm. H. Jones

9. Date of Registration: Jan 16 1901

10. Place of Registration: Town of Boston

11. Name of Registrar: Wm. H. Jones

12. Signature of Deceased: John A. Smith

13. Signature of Next of Kin: John A. Smith

14. Signature of Minister: Rev. J. B. Brown

15. Signature of Undertaker: John A. Smith

16. Signature of Coroner: John A. Smith

17. Signature of Jury: John A. Smith

18. Signature of Judge: John A. Smith

19. Signature of Sheriff: John A. Smith

20. Signature of Constable: John A. Smith

21. Signature of Town Clerk: John A. Smith

22. Signature of School Committee: John A. Smith

23. Signature of Board of Health: John A. Smith

24. Signature of Board of Police: John A. Smith

25. Signature of Board of Fire: John A. Smith

26. Signature of Board of Education: John A. Smith

27. Signature of Board of Public Works: John A. Smith

28. Signature of Board of Public Safety: John A. Smith

29. Signature of Board of Public Health: John A. Smith

30. Signature of Board of Public Charity: John A. Smith

31. Signature of Board of Public Education: John A. Smith

32. Signature of Board of Public Works: John A. Smith

33. Signature of Board of Public Safety: John A. Smith

34. Signature of Board of Public Health: John A. Smith

35. Signature of Board of Public Charity: John A. Smith

36. Signature of Board of Public Education: John A. Smith

37. Signature of Board of Public Works: John A. Smith

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52. Signature of Board of Public Works: John A. Smith

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99. Signature of Board of Public Health: John A. Smith

100. Signature of Board of Public Charity: John A. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6924
CERTIFICATE OF DEATH

Reg. Dist. No.

06918

1. PLACE OF DEATH
a. COUNTY

Kent

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chestertown

c. LENGTH OF STAY IN 1b

2 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Kent and Queen Anne's Hospital

d. STREET ADDRESS

308 S. Front Street

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

First

Addie

Middle

Last

Camille

4. DATE OF DEATH

Month

June

Day

18

Year

19 58

5. SEX

Female

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

April 27, 1885

9. AGE (In years last birthday)

73 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook and domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Nicholas Camille

14. MOTHER'S MAIDEN NAME

Wilmina Boyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-30-8296

17. INFORMANT

Address

Catherine Bridges, Phila. Pa.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X

DUE TO

Cerebral hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Arteriosclerosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 days

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Coronary artery disease

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. 11. p. m. 1920d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6-16, 1958, to 6-18, 1958, that I last saw the deceased alive on 6-18, 1958, and that death occurred at 9:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE

A.C. Dick

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type)

A.C. Dick

Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/22/58

22c. NAME OF CEMETERY OR CREMATORY

Guthrie Cemetery

22d. LOCATION (City, town, or county)

Guthrie

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James B. Darby, Boston, Md.

24a. REC'D BY REGISTRAR

DATE JUN 26 58

24b. REGISTRAR'S SIGNATURE

W. H. Haden

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of the deceased: <i>JOSE MARIA GARCIA</i></p>	
<p>2. Date of birth: <i>15/03/1925</i></p>	
<p>3. Place of birth: <i>San Pedro de Macoris, D.R.</i></p>	
<p>4. Date of death: <i>10/08/1985</i></p>	
<p>5. Place of death: <i>San Pedro de Macoris, D.R.</i></p>	
<p>6. Cause of death: <i>Heart failure</i></p>	
<p>7. Signature of the physician: <i>[Signature]</i></p>	
<p>8. Signature of the witness: <i>[Signature]</i></p>	
<p>9. Signature of the registrar: <i>[Signature]</i></p>	
<p>10. Date of registration: <i>12/08/1985</i></p>	
<p>11. Place of registration: <i>San Pedro de Macoris, D.R.</i></p>	
<p>12. Remarks: <i>[Blank]</i></p>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6925

CERTIFICATE OF DEATH

Reg. Dist. No.

06919

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent and Queen Anne's</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Allie A. JOHNSON</u>		4. DATE OF DEATH Month Day Year <u>June 30 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1898</u>
9. AGE (In years last birthday) <u>60 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Hosp. Records</u>		Address <u>Chestertown Kent</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C.V.R. disease</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28</u> , 19 <u>58</u> , to <u>June 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>58</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown Md</u> DATE SIGNED <u>6-30-58</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u>		M.D. <u>6-30-58</u>	
PHYSICIAN'S NAME (Type) <u>A. C. Dick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		ADDRESS <u>STILL POND, MD</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 2 58</u>		24b. REGISTRAR'S SIGNATURE <u>A.C. Dick</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
John Doe		Male		45		Jan 1, 1900		Boston, Mass.		Boston, Mass.		Heart Disease		Jan 15, 1945		10:00 AM		City Hall		John Doe		John Doe		John Doe	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Jane Smith		Female		30		Mar 10, 1915		New York, N.Y.		New York, N.Y.		Accident		Mar 20, 1945		2:00 PM		Home		Jane Smith		Jane Smith		Jane Smith	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Robert Johnson		Male		60		Sep 5, 1885		Chicago, Ill.		Chicago, Ill.		Stroke		Apr 10, 1945		8:00 AM		Hospital		Robert Johnson		Robert Johnson		Robert Johnson	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Mary White		Female		75		Nov 12, 1870		Philadelphia, Pa.		Philadelphia, Pa.		Old Age		Apr 25, 1945		11:00 AM		Home		Mary White		Mary White		Mary White	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
William Brown		Male		55		Jul 3, 1890		Cleveland, Ohio		Cleveland, Ohio		Heart Disease		May 5, 1945		9:00 AM		Hospital		William Brown		William Brown		William Brown	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Elizabeth Green		Female		40		Dec 18, 1905		Detroit, Mich.		Detroit, Mich.		Accident		May 15, 1945		3:00 PM		Home		Elizabeth Green		Elizabeth Green		Elizabeth Green	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Frank Miller		Male		35		Aug 22, 1910		St. Louis, Mo.		St. Louis, Mo.		Heart Disease		May 20, 1945		7:00 AM		Hospital		Frank Miller		Frank Miller		Frank Miller	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Grace Wilson		Female		25		Apr 1, 1920		San Francisco, Cal.		San Francisco, Cal.		Accident		Jun 1, 1945		1:00 PM		Home		Grace Wilson		Grace Wilson		Grace Wilson	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Charles Davis		Male		65		Mar 15, 1880		Pittsburgh, Pa.		Pittsburgh, Pa.		Stroke		Jun 10, 1945		10:00 AM		Hospital		Charles Davis		Charles Davis		Charles Davis	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Helen Taylor		Female		50		Oct 5, 1895		New Orleans, La.		New Orleans, La.		Heart Disease		Jun 25, 1945		12:00 PM		Hospital		Helen Taylor		Helen Taylor		Helen Taylor	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
George Anderson		Male		40		Jun 10, 1905		Portland, Ore.		Portland, Ore.		Accident		Jul 5, 1945		4:00 PM		Home		George Anderson		George Anderson		George Anderson	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Margaret Clark		Female		30		Sep 1, 1915		San Diego, Cal.		San Diego, Cal.		Heart Disease		Jul 15, 1945		9:00 AM		Hospital		Margaret Clark		Margaret Clark		Margaret Clark	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Richard King		Male		55		Dec 10, 1890		Cincinnati, Ohio		Cincinnati, Ohio		Stroke		Jul 20, 1945		11:00 AM		Hospital		Richard King		Richard King		Richard King	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Lillian Scott		Female		45		Mar 20, 1900		Los Angeles, Cal.		Los Angeles, Cal.		Accident		Aug 1, 1945		2:00 PM		Home		Lillian Scott		Lillian Scott		Lillian Scott	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Thomas Lee		Male		60		Jan 1, 1885		New York, N.Y.		New York, N.Y.		Heart Disease		Aug 10, 1945		8:00 AM		Hospital		Thomas Lee		Thomas Lee		Thomas Lee	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Aunt Mary		Female		80		Nov 1, 1865		Boston, Mass.		Boston, Mass.		Old Age		Aug 25, 1945		10:00 AM		Home		Aunt Mary		Aunt Mary		Aunt Mary	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
James White		Male		35		Apr 10, 1910		Chicago, Ill.		Chicago, Ill.		Accident		Sep 5, 1945		3:00 PM		Home		James White		James White		James White	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Elizabeth Brown		Female		50		Jul 15, 1895		New York, N.Y.		New York, N.Y.		Heart Disease		Sep 15, 1945		11:00 AM		Hospital		Elizabeth Brown		Elizabeth Brown		Elizabeth Brown	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Robert Green		Male		40		Oct 1, 1905		San Francisco, Cal.		San Francisco, Cal.		Accident		Oct 10, 1945		4:00 PM		Home		Robert Green		Robert Green		Robert Green	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Mary Clark		Female		30		Mar 10, 1915		Detroit, Mich.		Detroit, Mich.		Heart Disease		Oct 20, 1945		9:00 AM		Hospital		Mary Clark		Mary Clark		Mary Clark	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
William King		Male		55		Jun 1, 1890		Cleveland, Ohio		Cleveland, Ohio		Stroke		Nov 5, 1945		10:00 AM		Hospital		William King		William King		William King	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Grace Taylor		Female		45		Sep 1, 1900		Los Angeles, Cal.		Los Angeles, Cal.		Accident		Nov 15, 1945		2:00 PM		Home		Grace Taylor		Grace Taylor		Grace Taylor	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Charles Anderson		Male		60		Jan 1, 1885		New York, N.Y.		New York, N.Y.		Heart Disease		Nov 25, 1945		8:00 AM		Hospital		Charles Anderson		Charles Anderson		Charles Anderson	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Lillian Scott		Female		35		Apr 10, 1910		San Francisco, Cal.		San Francisco, Cal.		Accident		Dec 1, 1945		3:00 PM		Home		Lillian Scott		Lillian Scott		Lillian Scott	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Thomas Lee		Male		50		Jul 15, 1895		Cincinnati, Ohio		Cincinnati, Ohio		Stroke		Dec 15, 1945		11:00 AM		Hospital		Thomas Lee		Thomas Lee		Thomas Lee	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Elizabeth Brown		Female		40		Oct 1, 1905		Detroit, Mich.		Detroit, Mich.		Heart Disease		Dec 20, 1945		9:00 AM		Hospital		Elizabeth Brown		Elizabeth Brown		Elizabeth Brown	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Robert Green		Male		30		Mar 10, 1915		San Francisco, Cal.		San Francisco, Cal.		Accident		Jan 5, 1946		4:00 PM		Home		Robert Green		Robert Green		Robert Green	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Mary Clark		Female		50		Jun 1, 1895		New York, N.Y.		New York, N.Y.		Heart Disease		Jan 15, 1946		10:00 AM		Hospital		Mary Clark		Mary Clark		Mary Clark	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
William King		Male		40		Sep 1, 1905		Los Angeles, Cal.		Los Angeles, Cal.		Accident		Jan 25, 1946		2:00 PM		Home		William King		William King		William King	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Grace Taylor		Female		30		Apr 10, 1915		Detroit, Mich.		Detroit, Mich.		Heart Disease		Feb 5, 1946		11:00 AM		Hospital		Grace Taylor		Grace Taylor		Grace Taylor	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Charles Anderson		Male		55		Jul 15, 1895		Cincinnati, Ohio		Cincinnati, Ohio		Stroke		Feb 15, 1946		8:00 AM		Hospital		Charles Anderson		Charles Anderson		Charles Anderson	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Lillian Scott		Female		35		Oct 1, 1910		San Francisco, Cal.		San Francisco, Cal.		Accident		Feb 25, 1946		3:00 PM		Home		Lillian Scott		Lillian Scott		Lillian Scott	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Thomas Lee		Male		45		Jan 1, 1901		New York, N.Y.		New York, N.Y.		Heart Disease		Mar 5, 1946		9:00 AM		Hospital		Thomas Lee		Thomas Lee		Thomas Lee	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Elizabeth Brown		Female		35		Apr 10, 1910		San Francisco, Cal.		San Francisco, Cal.		Accident		Mar 15, 1946		4:00 PM		Home		Elizabeth Brown		Elizabeth Brown		Elizabeth Brown	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Robert Green		Male		25		Sep 1, 1920		Detroit, Mich.		Detroit, Mich.		Heart Disease		Mar 25, 1946		10:00 AM		Hospital		Robert Green		Robert Green		Robert Green	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
Mary Clark		Female		40		Jul 15, 1895		Cincinnati, Ohio		Cincinnati, Ohio		Stroke		Apr 5, 1946		11:00 AM		Hospital		Mary Clark		Mary Clark		Mary Clark	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
William King		Male		30		Oct 1, 1915		San Francisco, Cal.		San Francisco, Cal.		Accident		Apr 15, 1946		2:00 PM		Home		William King					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BPA 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06920

1. PLACE OF DEATH a. COUNTY Kent County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golts	c. LENGTH OF STAY IN 1b 3 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golts	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Linda Leoma Lucas		4. DATE OF DEATH Month Day Year June 28 19 58	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1954
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chestertown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harold Lucas		14. MOTHER'S MAIDEN NAME Susie Frances Johns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Birth Reg. Notice		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into well.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. June 28 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Golts Kent Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Arthur T. Keefe, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/30/58	
EXAMINER'S NAME (Type) Arthur T. Keefe, Jr., M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/1/58	
22c. NAME OF CEMETERY OR CREMATORY GOLT CEM.		22d. LOCATION (City, town, or county) (State) GOLT, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		24a. REC'D BY REGISTRAR DATE JUL 7 '58	
24b. REGISTRAR'S SIGNATURE W. H. Search			

NEW YORK STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER, CERTIFICATE OF DEATH

Last Sighting

Office

2 Party

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Female - Fair - 5' 10" - 125 lbs. - 1900

604

1900-1901, No.

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6926

CERTIFICATE OF DEATH

06921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kent & Queen Annes General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Earl Last Perry		4. DATE OF DEATH Month June Day 8 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1886 (exactly 72 yrs.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Perry		14. MOTHER'S MAIDEN NAME Ella Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-12-5856	
17. INFORMANT Hospital records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) several years			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Pulmonary Emphysema (10 years)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 7 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7 , 19 58 , to June 8 , 19 58 , that I last saw the deceased alive on June 8 , 19 58 , and that death occurred at 6:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr, M.D.		DATE SIGNED June 8, 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/11/58	22c. NAME OF CEMETERY OR CREMATORY Chester Cem.	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06922

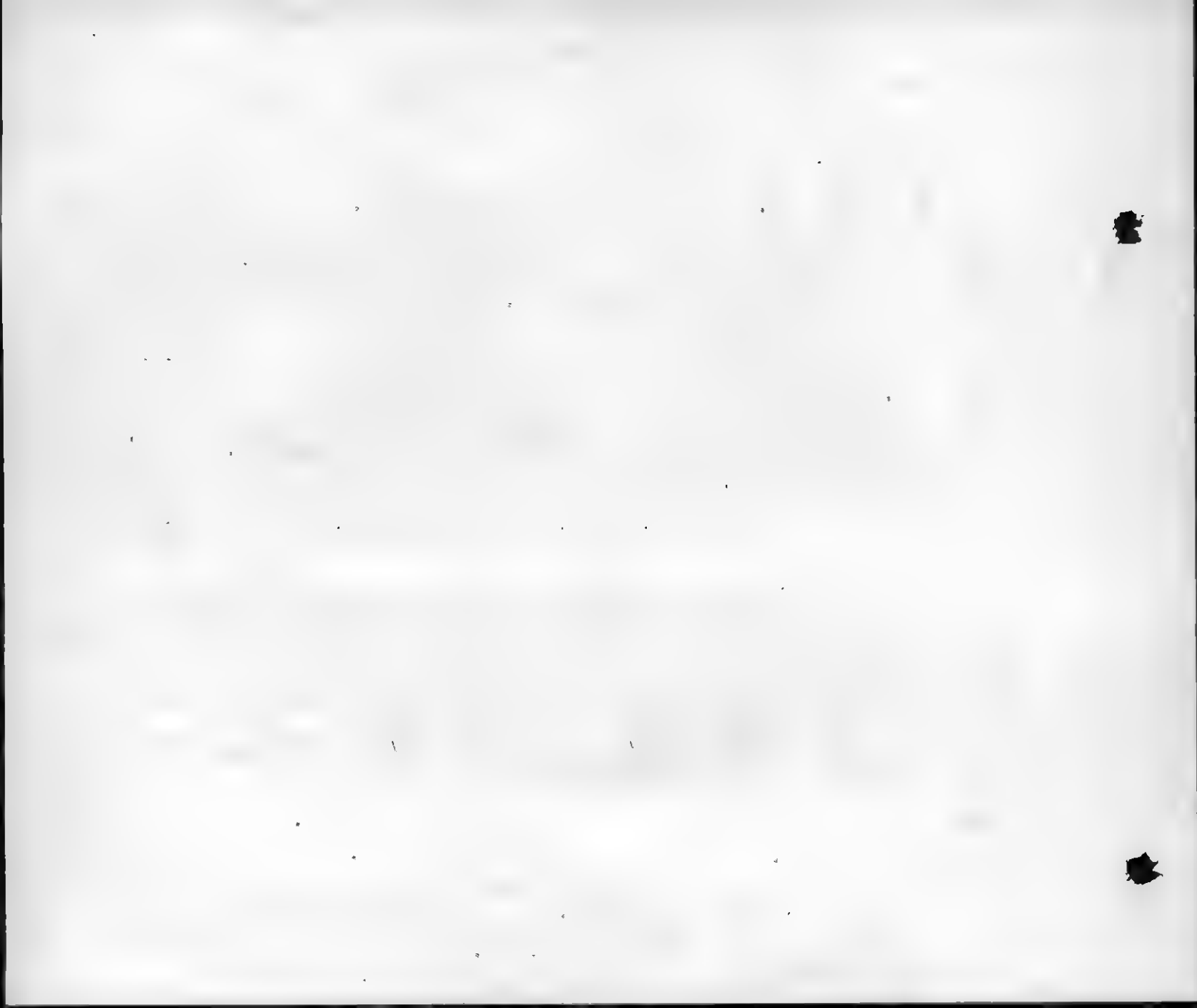
6927

CERTIFICATE OF DEATH

Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Chestertown, c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 Court St.		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 208 Court St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Eneva Richardson First Middle Last 4. DATE OF DEATH June 1, 1958 Month Day Year		5 SEX female 6 COLOR OR RACE colored 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH Nov. 27, 1910 9 AGE (In years last birthday) 47 yrs IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Wm. Chester		14. MOTHER'S MAIDEN NAME Katie Chester	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown, (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO yes	
17. INFORMANT Thomas Richardson Address 208 Court St. Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 401.1 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic insufficiency & Aortitis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 months known for 30 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/31 , 19 55 , to 6/1 , 19 58 , that I last saw the deceased alive on 6/1 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert W. Farr M.D. Chestertown, Md. June 2, 1958 PHYSICIAN'S NAME (Type) Robert W. Farr Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1958	
22c. NAME OF CEMETERY OR CREMATORY James Cem.		22d. LOCATION (City, town, or county) (State) near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR JUN 4 '58 24b. REGISTRAR'S SIGNATURE Alb. Leach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

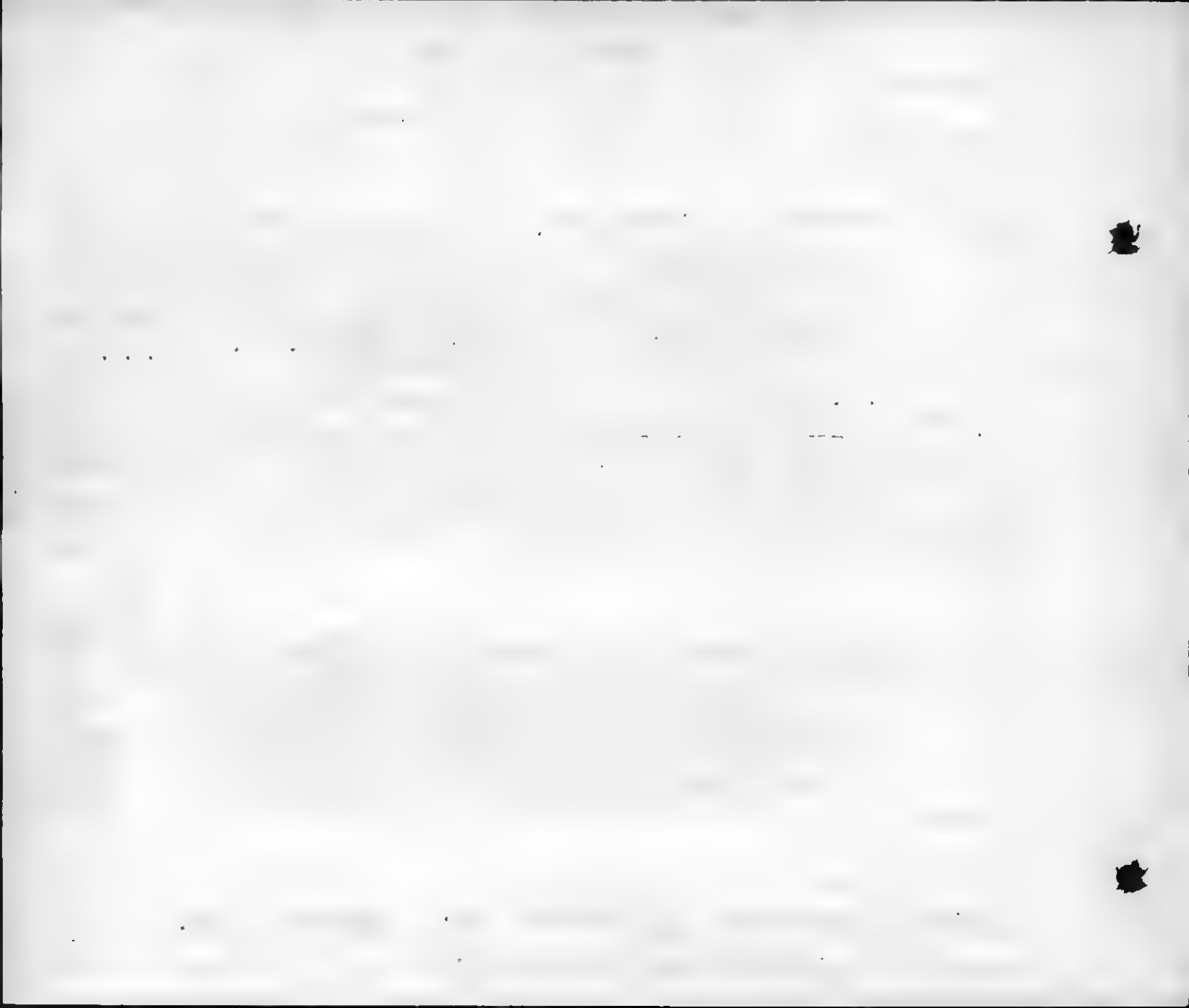
6028

CERTIFICATE OF DEATH

06923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 3 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville 17x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John F. Stokes				4. DATE OF DEATH Month June Day 23 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 11 1909		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker		10b. KIND OF BUSINESS OR INDUSTRY Cashier		11. BIRTHPLACE (State or foreign country) Worton Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. O. Stokes				14. MOTHER'S MAIDEN NAME Katherine Friel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-3925		17. INFORMANT Margaret Metcalfe Stokes - Sudlersville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/21 , 19 58 , to 6/23 , 19 58 , that I last saw the deceased alive on 6/23 , 19 58 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas J. Solon				ADDRESS (Street, city or town, state) T. Thomas J. Solon		DATE SIGNED 6/23/58	
PHYSICIAN'S NAME (Type) Thomas J. Solon				Chestertown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 26/58		22c. NAME OF CEMETERY OR CREMATORY Sudlersville Md.		22d. LOCATION (City, town, or county) (State) Sudlersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
				24b. REGISTRAR'S SIGNATURE Overseer			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6934

CERTIFICATE OF DEATH

Reg. Dist. No.

06924

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond				c. LENGTH OF STAY IN lb Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louise Middle Toulson Last Toulson				4. DATE OF DEATH Month June Day 14 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1890	
9. AGE (In years last birthday) yn. 67		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Henry Toulson		14. MOTHER'S MAIDEN NAME Susan Emma Wilmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-20-0001		17. INFORMANT Address Mrs. Mary Clark Still Pond, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of lung 170X DUE TO (b) Carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac decompensation						INTERVAL BETWEEN ONSET AND DEATH 1 year 6 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 13, 1958 to June 14, 1958 , that I last saw the deceased alive on June 13, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Florence Deringer Joyce M.D. Worton, Md. 6/14/58							
ACTUAL SIGNATURE Florence Deringer Joyce				PHYSICIAN'S NAME (Type) Florence Deringer Joyce			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/58		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE JUN 17 '58	
				24b. REGISTRAR'S SIGNATURE Overman			



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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grassville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent Queen Anne Hospital</u>		d. STREET ADDRESS <u>Grassville</u>	
3. NAME OF DECEASED (Type or print) First <u>"Baby Girl"</u> Middle <u>TURNER</u> Last <u>TURNER</u>		4. DATE OF DEATH <u>June 20</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30-1958</u>
9. AGE <u>3</u> years <u>3</u> months <u>3</u> days		10. DATE OF BIRTH <u>May 30-1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesapeake Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reason William Turner</u>		14. MOTHER'S MAIDEN NAME <u>Rena Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>none</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>R William Turner</u>		Address <u>Grassville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Prothrombin Deficiency</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Premature 14 30 week</u> DUE TO <u>Gestation</u> (c) <u>Gestation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 30, 1958</u> to <u>June 2, 1958</u> , that I last saw the deceased alive on <u>June 1, 1958</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cantraville Md</u> DATE SIGNED <u>June 2, 1958</u>			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		DATE SIGNED <u>June 2, 1958</u>	
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Battle Neck Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Stearnsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Burton of Burton Bros. Churchville Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 4 1958</u>	24b. REGISTRAR'S SIGNATURE <u>W. A. Newkirk</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6935

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Kent MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton (Several Years)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton (RFD)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home (Bigwoods)		d. STREET ADDRESS (Bigwoods RFD)	
3. NAME OF DECEASED (Type or print) Robert McKinley Whittington		4. DATE OF DEATH Month June Day 17 Year 1958	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1897
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during 60 days of working life, even if retired) Boilmaker (Bancroft Co.)		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Wright Whittington		14. MOTHER'S MAIDEN NAME Emma Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW 1		16. SOCIAL SECURITY NO. 221-03-0660	
17. INFORMANT Mary Whittington		Address Worton Md. RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Disease 134X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertension DUE TO (c) Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16 , 19 58 , to June 17 , 19 58 , that I last saw the deceased alive on June 16 , 19 58 , and that death occurred at 5:00 A. M. from the causes and on the date stated above			
ACTUAL SIGNATURE Norbert C. Nitsch		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED June 17, 1958	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch		Rock Hall, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Olivet Hill Cem.		22d. LOCATION (City, town, or county) (State) nr. Galena, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR June 10 '58		24b. REGISTRAR'S SIGNATURE Q. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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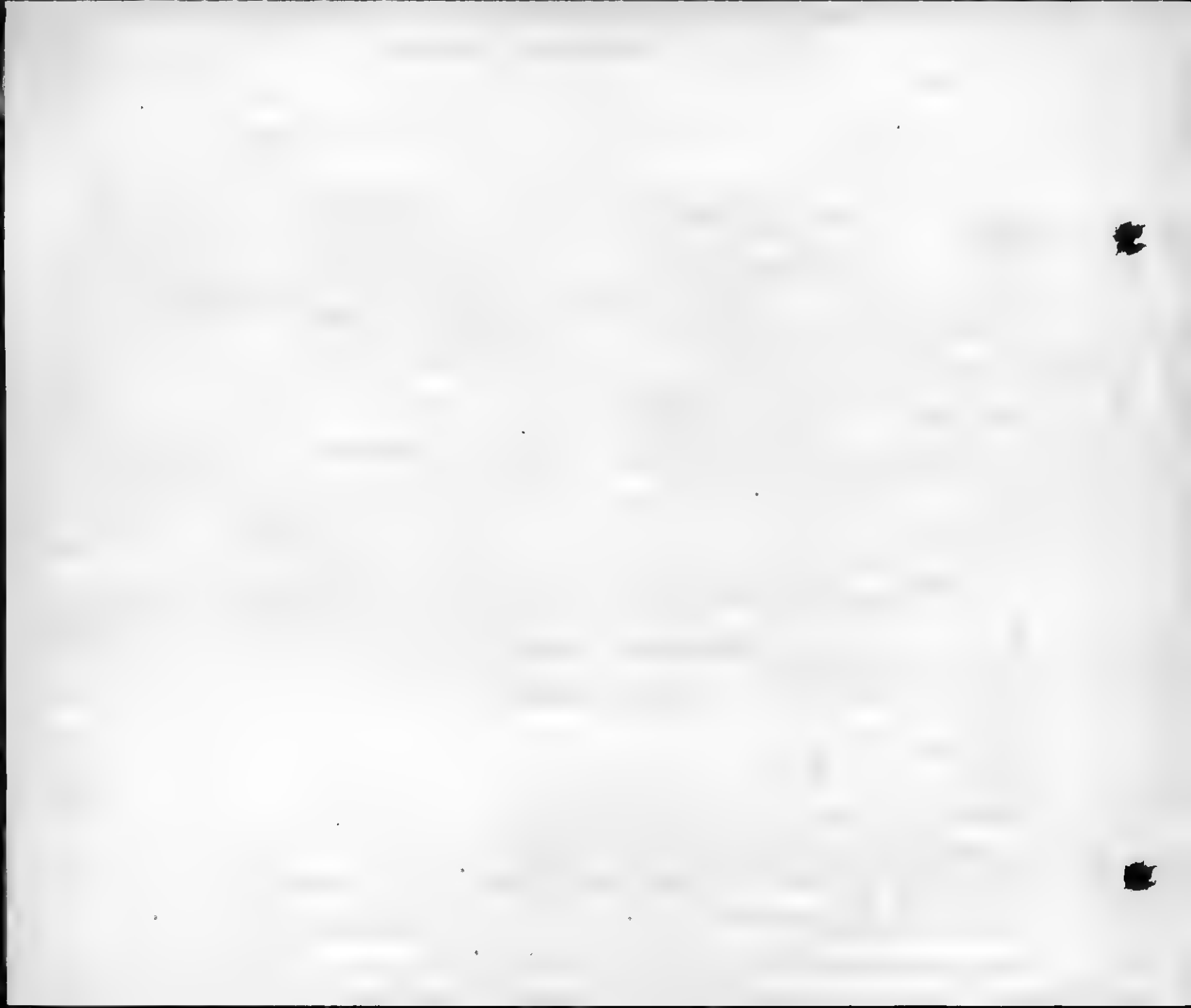
6930

CERTIFICATE OF DEATH

Reg. Dist. No.

06927

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>			c. LENGTH OF STAY IN 1b <u>9.2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 N. Queen Street</u>				d. STREET ADDRESS <u>118 N. Queen St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hope</u> Middle <u>Wickes</u> Last <u>Wickes</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1958</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1865</u>	
9. AGE (In years last birthday) <u>92 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles H. Wickes</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Whaland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>—</u>		17. INFORMANT Address <u>Mrs Elizabeth Westcott</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complications of old age</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>5</u> , to <u>June 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>58</u> , and that death occurred at <u>10⁰⁰ AM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>A.C. Dick</u>				M.D. <u>Chestertown Md</u>		DATE SIGNED <u>6-27-58</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>				<u>A.C. Dick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06928

6931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>15 Minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Ann's Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1896</u>	
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Moore</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Greenwood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Wm. Ernest Willis Kennedyville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>4 H.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia, left</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 25, 1958</u> , to <u>June 28, 1958</u> , that I last saw the deceased alive on <u>June 25, 1958</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D. <u>Worton, Md.</u>				DATE SIGNED <u>6/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u>				<u>Worton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u>				ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Worton, Md.</u>			

6932

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kentland Memorial Community Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Wilson</u> First Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1876</u> 9. AGE (In years lost birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Starling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>107-18-6037</u>	
17. INFORMANT <u>Hosp. Records - Chestertown, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & coronary artery disease</u> DUE TO (c) <u>6 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-22</u> , 19 <u>58</u> , to <u>6-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. <u>Chestertown, Md.</u>		DATE SIGNED <u>6-5-58</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Search</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

